(ii) The trading partners and geographical areas the Secretary approves for testing.

(iii) Any other conditions for approving the exception.

(2) *Exception denied.* If the Secretary does not grant an exception, the notification explains the reasons the Secretary considers the proposed modification would not be a significant improvement to the current standard and any other rationale for the denial.

(d) *Organization's report on test results.* Within 90 days after the test is completed, an organization that receives an exception must submit a report on the results of the test, including a cost-benefit analysis, to a location specified by the Secretary by notice in the FEDERAL REGISTER.

(e) *Extension allowed.* If the report submitted in accordance with paragraph (d) of this section recommends a modification to the standard, the Secretary, on request, may grant an extension to the period granted for the exception.

Subpart J—Code Sets

§ 162.1000 General requirements.

When conducting a transaction covered by this part, a covered entity must meet the following requirements:

(a) *Medical data code sets.* Use the applicable medical data code sets described in § 162.1002 as specified in the implementation specification adopted under this part that are valid at the time the health care is furnished.

(b) *Nonmedical data code sets.* Use the nonmedical data code sets as described in the implementation specifications adopted under this part that are valid at the time the transaction is initiated.

§ 162.1002 Medical data code sets.

The Secretary adopts the following code set maintaining organization's code sets as the standard medical data code sets:

(a) *International Classification of Diseases, 9th Edition, Clinical Modification, (ICD–9–CM), Volumes 1 and 2* (including The Official ICD–9–CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

(1) Diseases.

(2) Injuries.

(3) Impairments.

(4) Other health problems and their manifestations.

(5) Causes of injury, disease, impairment, or other health problems.

(b) *International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures* (including The Official ICD–9–CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals:

(1) Prevention.

(2) Diagnosis.

(3) Treatment.

(4) Management.

(c) *National Drug Codes* (NDC), as maintained and distributed by HHS, in collaboration with drug manufacturers, for the following:

(1) Drugs

(2) Biologics.

(d) *Code on Dental Procedures and Nomenclature,* as maintained and distributed by the American Dental Association, for dental services.

(e) The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS),* as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT–4),* as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following:

(1) Physician services.

(2) Physical and occupational therapy services.

(3) Radiologic procedures.

(4) Clinical laboratory tests.

(5) Other medical diagnostic procedures.

(6) Hearing and vision services.

(7) Transportation services including ambulance.

(f) The *Health Care Financing Administration Common Procedure Coding System (HCPCS),* as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services. These

items include, but are not limited to, the following:

(1) Medical supplies.

(2) Orthotic and prosthetic devices.

(3) Durable medical equipment.

§ 162.1011 Valid code sets.

Each code set is valid within the dates specified by the organization responsible for maintaining that code set.

Subpart K—Health Care Claims or Equivalent Encounter Information

§ 162.1101 Health care claims or equivalent encounter information transaction.

The health care claims or equivalent encounter information transaction is the transmission of either of the following:

(a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.

(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

§ 162.1102 Standards for health care claims or equivalent encounter information.

The Secretary adopts the following standards for the health care claims or equivalent encounter information transaction:

(a) *Retail pharmacy drug claims.* The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1, 1996. The implementation specifications are available at the addresses specified in § 162.920(a)(2).

(b) *Dental Health Care Claims.* The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097. The implementation specification is available at the addresses specified in § 162.920(a)(1).

(c) *Professional Health Care Claims.* The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098. The implementation specification is available at the addresses specified in § 162.920(a)(1).

(d) *Institutional Health Care Claims.* The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096. The implementation specification is available at the addresses specified in § 162.920(a)(1).

Subpart L—Eligibility for a Health Plan

§ 162.1201 Eligibility for a health plan transaction.

The eligibility for a health plan transaction is the transmission of either of the following:

(a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) Eligibility to receive health care under the health plan.

(2) Coverage of health care under the health plan.

(3) Benefits associated with the benefit plan.

(b) A response from a health plan to a health care provider's (or another health plan's) inquiry described in paragraph (a) of this section.

§ 162.1202 Standards for eligibility for a health plan.

The Secretary adopts the following standards for the eligibility for a health plan transaction:

(a) *Retail pharmacy drugs.* The NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1, 1996. The implementation specifications are available at the addresses specified in § 162.920(a)(2).

(b) *Dental, professional, and institutional.* The ASC X12N 270/271–Health Care Eligibility Benefit Inquiry and